Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5207HIC	A. BUILDING _____ B. WING _____	08/06/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GEM, LLC	5483 WESLEYAN CT LAS VEGAS, NV 89113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comment This Statement of Deficiencies was generated as a result of an initial State Licensure survey conducted in your facility on August 6, 2008. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care (HIC), adopted by the State Board of Health on November 29, 1999. The facility has applied for a license as a Home for Individual Residential Care facility which provides food, shelter, assistance and limited supervision for a maximum of two (2) people. The census at the time of the survey was zero. One employee file was reviewed The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil actions or other claims for relief that may be available to any party under applicable federal, state or local laws. There were no deficiencies found during the survey. No further action is necessary concerning this report. Please retain this copy for your records.	H 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE